

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, the 3 sheets should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9915

## CERTIFICATE OF DEATH

09897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospt.</u>		d. STREET ADDRESS <u>703 Arundel Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Sherrill S.</u> Middle <u>Adams</u> Last <u>Adams</u>		4. DATE OF DEATH Month <u>October</u> Day <u>8</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Administration</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospitals</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Adams</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>1008-10-1111</u>	
17. INFORMANT <u>Rosestelle Adams</u> Address <u># 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of myocardium + cardiac tamponade</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Acute Anterior Myocardial Infarction</u> DUE TO (b) <u>12 hrs</u> (c) <u>2 hrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes M. + hypercholesterolemia</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/8/56</u> , 1956, to <u>10/8/56</u> , that I last saw the deceased alive on <u>10/8/56</u> , 1956, and that death occurred at <u>1008</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		DATE SIGNED <u>10/10/56</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-11-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>10/11/56</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>J. D. Smith</u>	

**Figure 1**

1

1

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

BUREAU V. S.

OCT 15 1956

RECEIVED

61

9916

## CERTIFICATE OF DEATH

69898

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>		d. STREET ADDRESS <u>92 Conduit St.</u>	
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>E</u> Last <u>ANDERSON</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5, 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Stappf</u>		14. MOTHER'S MAIDEN NAME <u>"UNK"</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>James Anderson</u>	
17. INFORMANT <u>James Anderson</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple vitamin deficiencies</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 18, 1956</u> , to <u>Oct. 14, 1956</u> , that I last saw the deceased alive on <u>Oct. 14, 1956</u> , and that death occurred at <u>1:05 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Henderson</u>		ADDRESS (Street, city or town, state) <u>92 Cathedral St.</u> DATE SIGNED <u>10/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Amegulis, G.M.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-17-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Taylor &amp; Sons</u>		24. REG'D BY REGISTRAR <u>151559</u> 24b. REGISTRAR'S SIGNATURE <u>J. French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in boxes, the funeral director, pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOKEAD A. 3

1. *Journal of the American Medical Association*, 1997; 277: 1033-1036.

151502

**BUREAU V. S.**

OCT 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be retained by the registrar.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9932  
CERTIFICATE OF DEATH

Reg. Dist. No.

09899 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>36 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		d. STREET ADDRESS <u>825 Woodyear Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lottie</u> Middle <u>Goodman</u> Last <u>Anderson</u>		4. DATE OF DEATH Month <u>10</u> Day <u>26</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/9/98</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Domestic</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>John T. Goodman</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Goodman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/21</u> , 19 <u>56</u> , to <u>10/26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>56</u> , and that death occurred at <u>12:15a</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>10/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/30/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Katie R. Williams</u>		24a. REC'D BY REGISTRAR <u>322 N. Schroeder St.</u>	
24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>		DATE <u>10/30/1956</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED John T. [illegible]		SEX Male		AGE 35 years		DATE OF DEATH [illegible]	
PLACE OF DEATH [illegible]		CITY [illegible]		COUNTY [illegible]		STATE [illegible]	
OCCUPATION [illegible]		EDUCATION [illegible]		RELIGION [illegible]		MARRIAGE [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]		IMMEDIATE CAUSE [illegible]		FUNDAMENTAL CAUSE [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF REGISTRAR [illegible]		SIGNATURE OF WITNESS [illegible]		SIGNATURE OF WITNESS [illegible]	
DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]		DATE OF SIGNATURE [illegible]	

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9933

## CERTIFICATE OF DEATH

09901

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MARYLAND</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Burlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort G. G. Meade</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROBERT</u> First <u>ELIIS</u> Middle <u>BRADMAN</u> Last				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8 October 1956</u>	
9. AGE (In years last birthday) yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Bradman</u>				14. MOTHER'S MAIDEN NAME <u>Susan Biddle Grosskreuz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Father, 1836 B. Reece Road, Ft Meade, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>760.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Oct</u> 19 <u>56</u> to <u>10 Oct</u> 19 <u>56</u> , that I last saw the deceased alive on <u>10 Oct</u> 19 <u>56</u> , and that death occurred at <u>1745 PM</u> , from the causes and on the date stated above. <u>Herbert L. Nadelman</u> ADDRESS (Street, city or town, state) DATE SIGNED M.D. <u>U. S. Army Hospital, Ft G G Meade, Md.</u> <u>11 Oct 56</u>							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) <u>HERBERT L. NADELMAN, CAPT, MC</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>12 Oct 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. Saylor, INC., Baltimore, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>11 Oct 56</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Saylor, 1st Lt, MSC</u>	

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BUREAU V. S.

1956 21 10

RECEIVED



9934

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>River Road</u>				d. STREET ADDRESS <u>River Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anna Marie Brown</u>				4. DATE OF DEATH Month Day Year <u>October 16, 1956</u> 19			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1944</u>		9. AGE (In years last birthday) <u>11</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Raymond Charles Brown, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Lillian M. Eckard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Raymond C. Brown, Sr. River Road, Linthicum</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Measles Encephalitis as a baby</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/20</u> , 19 <u>53</u> , to <u>10/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John C. Healy</u> M.D.				ADDRESS (Street, city or town, state) <u>Dadelorfe, Md</u>		DATE SIGNED <u>10/16/56</u>	
PHYSICIAN'S NAME (Type) <u>John C. Healy</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				ADDRESS <u>4107 Wilkens Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 22 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. H. Hubbard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

OCT 22 1956

RECEIVED

9938

CERTIFICATE OF DEATH

09903

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>York</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		c. LENGTH OF STAY IN 1b <u>6 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Meadow &amp; Garden Rds.</u>			d. STREET ADDRESS <u>Meadow &amp; Garden Rds.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>C.</u> Last <u>Bubb</u>			4. DATE OF DEATH Month <u>October</u> Day <u>27</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1871</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>York Co., Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			13. FATHER'S NAME <u>Cornelius Bressler</u>		
14. MOTHER'S MAIDEN NAME <u>Ellen Freed</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or this town) <u>No</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>  </u>			17. INFORMANT Name <u>Mrs. Kenneth Kainer</u> Address <u>Riviera Beach, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>Not Known</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month <u>  </u> Day <u>19</u> Year <u>  </u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 10, 1951</u> to <u>October 27, 1956</u> , that I last saw the deceased alive on <u>October 27, 1956</u> , and that death occurred at <u>9:05 P.M.</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>R.M. McLaughlin</u>			M.D. <u>BEOS Box 442 Pasadena, Md 1947/56</u>		
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>			DATE SIGNED <u>10/27/56</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 30, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stiltz Cemetery, Glen Rock, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Antunstein, New Freedom, Pa.</u>		ADDRESS <u>  </u>		24. REC'D BY REGISTRAR DATE <u>30 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>L.J. Adolph</u>					

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
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43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
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49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
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88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU V. 3

OCT 30 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69994

9936

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grasonville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>None listed</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Edward</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/10/09</b>	
9. AGE (In years lost birthday) <b>47</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>P. C. Butler</b>				14. MOTHER'S MAIDEN NAME <b>Ida Bolton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Not given</b>			
17. INFORMANT <b>Hospital Records</b>				Address <b>Crownsville State Hospital Crownsville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Food in trachea</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/3</b> , 19 <b>56</b> , to <b>10/17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/17</b> , 19 <b>56</b> , and that death occurred at <b>11:10a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>10/17/56</b> ACTUAL SIGNATURE <b>Ludwig Benedict</b> M.D. PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Robinson's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Grasonville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. Johnson</b>				ADDRESS <b>Annapolis</b>		24a. REC'D BY REGISTRAR <b>Oct 22 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. M. Jay</b>			



CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		10/10/1910		Boston, Mass.		Boston, Mass.		Heart Disease		Home		10:30 PM		J. Doe, M.D.		J. Doe, Registrar	
Occupation		Marital Status		Education		Religion		Race		Color		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
Teacher		Married		High School		Roman Catholic		White		White		10/10/1955		10:30 PM		Home		J. Doe, M.D.		J. Doe, Registrar	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death	
10/10/1955		10:30 PM		Home		J. Doe, M.D.		J. Doe, Registrar		10/10/1955		10:30 PM		Home		J. Doe, M.D.		J. Doe, Registrar		10/10/1955	

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OCT 22 1955  
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# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS</u>		c. LENGTH OF STAY IN lb <u>28 EAST ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A.A. GENERAL Hospt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>NICHOLAS G. CASSAUETIS</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/1894</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COOK</u>	
11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE CASSAUETIS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA CHADERIS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <input checked="" type="checkbox"/> <u>1918-1919</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MARIE CASSAUETIS</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Vascular Disease</u> YES. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/11</u> , 19 <u>56</u> , to <u>10/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>56</u> , and that death occurred at <u>2054</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Ln, Annapolis Md</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Maurice F. Klawars</u> M.D.		PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWARS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/17/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOHIS NAT'L.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>		24a. REC'D BY, REGISTRAR DATE <u>10/16/56</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

VS A1S (4)  
ISM 9/SS

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		DATE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]	

BUREAU V. 2

OCT 18 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9937 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09906

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linthicum (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hammonds Lane</b>				d. STREET ADDRESS <b>617 Tranton Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Shirley</b> Middle <b>Ann</b> Last <b>C ooper</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1936</b>		9. AGE (In years last birthday) <b>19</b> yrs.	IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. F. &amp; G.</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Walter B. Cooper</b>				14. MOTHER'S MAIDEN NAME <b>Virgie Boggs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>408-60-8164</b>		17. INFORMANT <b>James Cooper,</b>		Address <b>same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of Skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <b>Multiple Lacerations</b> DUE TO (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Road</b>		20f. (City or town) (County) (State) <b>AA Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>G. H. Faubert</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>G. H. Faubert, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>10/20/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		22b. DATE THEREOF <b>10/21/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Crossville, Tenn.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James H. Kirkley</i> <b>Hopping and Kirkley, Glen Burnie, Md.</b>				24a. REC'D BY REGISTRAR <b>OCT 23 56</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 POSTMEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Examiner		Signature of Physician	
John Doe		45		Male		White		Married		Teacher		Heart Disease		Home		Oct 20, 1956		10:00 AM		[Signature]		[Signature]	
Address		City		State		County		Zip		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Time of Death		Signature of Examiner		Signature of Physician	
123 Main St		Baltimore		MD		Baltimore		21201		1910		1956		1956		1956		10:00 AM		[Signature]		[Signature]	

BUREAU V. S.

OCT 28 1956

RECEIVED

REPORTED BY: [Name]  
 DATE: [Date]  
 TIME: [Time]



1

## INSTRUCTIONS

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. A full copy may be retained by the hospital or attending physician.

**2. FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9938 CERTIFICATE OF DEATH

09907

Reg. Dist. No. 22

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Severn TFD</u>		<u>2 years</u>		TOWN <u>Severn TFD</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>New Cut Road - Box 235</u>				STREET ADDRESS (If rural give location) <u>New Cut Road - Box 235</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ETA</u> (Middle) <u>-</u> (Last) <u>COX</u>				(Month) <u>Oct.</u> (Day) <u>16</u> (Year) <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>July 25, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Ramay</u>				14. MOTHER'S MAIDEN NAME <u>Jane (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Lillie B. Sylvia Same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>day 1, 1956</u> , to <u>Oct. 16, 1956</u> , that I last saw the deceased alive on <u>Oct. 15, 1956</u> , and that death occurred at <u>8:50</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Samuel Rubin</u> M.D.		ADDRESS (Street, city, town, state) <u>203 Catonsville Ave. Baltimore</u>		DATE SIGNED <u>Oct 14, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Oct. 29, 1958</u>	NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		LOCATION (City, town, or county) <u>Glen Burnie, Md.</u>		(State)	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <u>Clara Hoschup</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>		ADDRESS <u>Glen Burnie, Md.</u>			
DATE <u>10/26/56</u>							

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO BE RETURNED TO THE HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completed by the funeral director, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9939

## CERTIFICATE OF DEATH

Reg. Dist. No.

09998

28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenarden</b> <b>16X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Seventh Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Dawson</b> Last <b>Dawson</b>				4. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/87</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Not known</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>John M. Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Liza Dawson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service) <b>— —</b>		16. SOCIAL SECURITY NO. <b>579-09-3476</b>		17. INFORMANT <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrotic Hypertensive Arteriosclerotic Disease</b> DUE TO (c) <b>—</b>				INTERVAL BETWEEN ONSET AND DEATH <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Decubitus Ulcers</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Crownsville, Md.</b>				20g. (County) <b>Prince George's</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>9/25</b> , 19 <b>56</b> , to <b>10/17</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/17</b> , 19 <b>56</b> , and that death occurred at <b>10:45 p.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>10/18/56</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>				M.D. <b>—</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-22-56</b>		22b. DATE THEREOF <b>10-22-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. E. Jarvis</b>				ADDRESS <b>Co-1432-yar st NW</b>		24a. REC'D BY REGISTRAR <b>OCT 24 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>H. M. Joyce</b>			

CERTIFICATE OF DEATH

DECEASED NAME [Illegible]		SEX [Illegible]		AGE [Illegible]	
RACE [Illegible]		BIRTH DATE [Illegible]		BIRTH PLACE [Illegible]	
DECEASED ADDRESS [Illegible]		DECEASED CITY [Illegible]		DECEASED STATE [Illegible]	
DECEASED COUNTY [Illegible]		DECEASED ZIP CODE [Illegible]		DECEASED COUNTRY [Illegible]	
DECEASED OCCUPATION [Illegible]		DECEASED CAUSE OF DEATH [Illegible]		DECEASED MANNER OF DEATH [Illegible]	
DECEASED DATE OF DEATH [Illegible]		DECEASED TIME OF DEATH [Illegible]		DECEASED PLACE OF DEATH [Illegible]	
DECEASED SIGNATURE [Illegible]		DECEASED TITLE [Illegible]		DECEASED ADDRESS [Illegible]	
DECEASED CITY [Illegible]		DECEASED STATE [Illegible]		DECEASED COUNTRY [Illegible]	
DECEASED ZIP CODE [Illegible]		DECEASED COUNTRY [Illegible]		DECEASED COUNTRY [Illegible]	

BUREAU V. S.

OCT 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

9918

## CERTIFICATE OF DEATH

09909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL Hospt</u>		e. STREET ADDRESS <u>CARVEL HALL HOTEL</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ENID</u> <u>HORNE</u> <u>DEEM</u>		4. DATE OF DEATH Month Day Year <u>10</u> <u>30</u> <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1898</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES F. HORNE</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DURHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>ARM. CHAS. F. HORNE</u>		844 <sup>Address</sup> <u>WILCREST DRIVE</u> <u>POMONA, CAL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gen carcinoma</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca M breast</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Oct. 31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 30</u> , 19 <u>56</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Brossuch</u>		DATE SIGNED <u>11/3/56</u>	
PHYSICIAN'S NAME (Type) <u>S. Brossuch</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/5/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEMT.</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lytle &amp; Sons</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	



RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09910

9940

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD.</i> b. COUNTY <i>A. A. Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10-4th Ave. Glen Burnie. Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>10 Fourth Ave. S.W.</i>				d. STREET ADDRESS <i>Glen Burnie, Md.</i>			
3. NAME OF DECEASED (Type or print) First <i>Minnie</i> Middle <i>De Lashmuth</i> Last <i>De Lashmuth</i>				4. DATE OF DEATH Month <i>Oct.</i> Day <i>18</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>December 2, 1871</i>	
9. AGE (In years lost birthday) <i>84</i> yrs.		IF UNDER 1 YEAR Months <i>8</i> Days <i>18</i> Hours <i>15</i> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Fredrick Co. Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Fredrick Runkles</i>				14. MOTHER'S MAIDEN NAME <i>Unknown.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Mrs. Minnie Allison,</i>		Address <i>10-4th Ave. Glen Burnie Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the Stomach</i> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>							INTERVAL BETWEEN ONSET AND DEATH <i>2 years -</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>56</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
20f. (City or town) <i>—</i>				20g. (County) <i>—</i>		20h. (State) <i>—</i>	
21. I certify that I attended the deceased from <i>Jan. 1955</i> to <i>Oct 18</i> , 1956, that I last saw the deceased alive on <i>Oct 17</i> , 1956, and that death occurred at <i>2:45</i> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James S. Billingslea</i>				ADDRESS (Street, city or town, state) <i>108 Central Ave. Glen Burnie Md</i>			
DATE SIGNED <i>Oct 18, 1956</i>							
PHYSICIAN'S NAME (Type) <i>James S. Billingslea M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct-22-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mount Olivet</i>		22d. LOCATION (City, town, or county) (State) <i>Fredrick Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richardson</i>				ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 22 1956</i>	
				24b. REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>			

CERTIFICATE OF DEATH

0040

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

RECEIVED  
OCT 22 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be related by the hospital or attending physician.  
TO GENERAL REGISTRAR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9941

## CERTIFICATE OF DEATH

Reg. Dist. No.

09911

27

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 Hollins Ferry Rd.</u>				d. STREET ADDRESS <u>204 Hollins Ferry Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>LAURA</u> Middle <u>K.</u> Last <u>DOWNS</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1902</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel C. Ray</u>				14. MOTHER'S MAIDEN NAME <u>Amanda E. (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT Address <u>Mr. Sherman L. Ray - 3449 Roland Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Uterus</u> DUE TO <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1953</u> , to <u>Oct 28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 28</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>105 Conlies Ave.</u> DATE SIGNED <u>Glen Burnie Md</u>							
ACTUAL SIGNATURE <u>James S. Bellings</u>		M.D. <u>105 Conlies Ave.</u>					
PHYSICIAN'S NAME (Type) <u>James S. Bellings M.D.</u>		<u>Glen Burnie Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Baetsch</u>			ADDRESS <u>105 Conlies Ave.</u>		24a. REC'D BY REGISTRAR DATE <u>Nov. 1, 1956</u>	24b. REGISTRAR'S SIGNATURE <u>L. J. Sullivan</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

File No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERGYMAN		20. SIGNATURE OF BURIAL OFFICIAL		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF SUPERVISOR	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF BURIAL OFFICIAL		29. SIGNATURE OF FUNERAL HOME		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF SUPERVISOR	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF CLERGYMAN		36. SIGNATURE OF BURIAL OFFICIAL		37. SIGNATURE OF FUNERAL HOME		38. SIGNATURE OF CEMETERY		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF SUPERVISOR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERGYMAN		44. SIGNATURE OF BURIAL OFFICIAL		45. SIGNATURE OF FUNERAL HOME		46. SIGNATURE OF CEMETERY		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF SUPERVISOR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN		51. SIGNATURE OF CLERGYMAN		52. SIGNATURE OF BURIAL OFFICIAL		53. SIGNATURE OF FUNERAL HOME		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF SUPERVISOR	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF NEXT OF KIN		59. SIGNATURE OF CLERGYMAN		60. SIGNATURE OF BURIAL OFFICIAL		61. SIGNATURE OF FUNERAL HOME		62. SIGNATURE OF CEMETERY		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF SUPERVISOR	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF BURIAL OFFICIAL		69. SIGNATURE OF FUNERAL HOME		70. SIGNATURE OF CEMETERY		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF SUPERVISOR	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF CLERGYMAN		76. SIGNATURE OF BURIAL OFFICIAL		77. SIGNATURE OF FUNERAL HOME		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF SUPERVISOR	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERGYMAN		84. SIGNATURE OF BURIAL OFFICIAL		85. SIGNATURE OF FUNERAL HOME		86. SIGNATURE OF CEMETERY		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF SUPERVISOR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN		91. SIGNATURE OF CLERGYMAN		92. SIGNATURE OF BURIAL OFFICIAL		93. SIGNATURE OF FUNERAL HOME		94. SIGNATURE OF CEMETERY		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF SUPERVISOR	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF NEXT OF KIN		99. SIGNATURE OF CLERGYMAN		100. SIGNATURE OF BURIAL OFFICIAL		101. SIGNATURE OF FUNERAL HOME		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF INTERVIEWER		104. SIGNATURE OF SUPERVISOR	
105. SIGNATURE OF DECEASED		106. SIGNATURE OF NEXT OF KIN		107. SIGNATURE OF CLERGYMAN		108. SIGNATURE OF BURIAL OFFICIAL		109. SIGNATURE OF FUNERAL HOME		110. SIGNATURE OF CEMETERY		111. SIGNATURE OF INTERVIEWER		112. SIGNATURE OF SUPERVISOR	
113. SIGNATURE OF DECEASED		114. SIGNATURE OF NEXT OF KIN		115. SIGNATURE OF CLERGYMAN		116. SIGNATURE OF BURIAL OFFICIAL		117. SIGNATURE OF FUNERAL HOME		118. SIGNATURE OF CEMETERY		119. SIGNATURE OF INTERVIEWER		120. SIGNATURE OF SUPERVISOR	
121. SIGNATURE OF DECEASED		122. SIGNATURE OF NEXT OF KIN		123. SIGNATURE OF CLERGYMAN		124. SIGNATURE OF BURIAL OFFICIAL		125. SIGNATURE OF FUNERAL HOME		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF INTERVIEWER		128. SIGNATURE OF SUPERVISOR	
129. SIGNATURE OF DECEASED		130. SIGNATURE OF NEXT OF KIN		131. SIGNATURE OF CLERGYMAN		132. SIGNATURE OF BURIAL OFFICIAL		133. SIGNATURE OF FUNERAL HOME		134. SIGNATURE OF CEMETERY		135. SIGNATURE OF INTERVIEWER		136. SIGNATURE OF SUPERVISOR	
137. SIGNATURE OF DECEASED		138. SIGNATURE OF NEXT OF KIN		139. SIGNATURE OF CLERGYMAN		140. SIGNATURE OF BURIAL OFFICIAL		141. SIGNATURE OF FUNERAL HOME		142. SIGNATURE OF CEMETERY		143. SIGNATURE OF INTERVIEWER		144. SIGNATURE OF SUPERVISOR	
145. SIGNATURE OF DECEASED		146. SIGNATURE OF NEXT OF KIN		147. SIGNATURE OF CLERGYMAN		148. SIGNATURE OF BURIAL OFFICIAL		149. SIGNATURE OF FUNERAL HOME		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF INTERVIEWER		152. SIGNATURE OF SUPERVISOR	
153. SIGNATURE OF DECEASED		154. SIGNATURE OF NEXT OF KIN		155. SIGNATURE OF CLERGYMAN		156. SIGNATURE OF BURIAL OFFICIAL		157. SIGNATURE OF FUNERAL HOME		158. SIGNATURE OF CEMETERY		159. SIGNATURE OF INTERVIEWER		160. SIGNATURE OF SUPERVISOR	
161. SIGNATURE OF DECEASED		162. SIGNATURE OF NEXT OF KIN		163. SIGNATURE OF CLERGYMAN		164. SIGNATURE OF BURIAL OFFICIAL		165. SIGNATURE OF FUNERAL HOME		166. SIGNATURE OF CEMETERY		167. SIGNATURE OF INTERVIEWER		168. SIGNATURE OF SUPERVISOR	
169. SIGNATURE OF DECEASED		170. SIGNATURE OF NEXT OF KIN		171. SIGNATURE OF CLERGYMAN		172. SIGNATURE OF BURIAL OFFICIAL		173. SIGNATURE OF FUNERAL HOME		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF INTERVIEWER		176. SIGNATURE OF SUPERVISOR	
177. SIGNATURE OF DECEASED		178. SIGNATURE OF NEXT OF KIN		179. SIGNATURE OF CLERGYMAN		180. SIGNATURE OF BURIAL OFFICIAL		181. SIGNATURE OF FUNERAL HOME		182. SIGNATURE OF CEMETERY		183. SIGNATURE OF INTERVIEWER		184. SIGNATURE OF SUPERVISOR	
185. SIGNATURE OF DECEASED		186. SIGNATURE OF NEXT OF KIN		187. SIGNATURE OF CLERGYMAN		188. SIGNATURE OF BURIAL OFFICIAL		189. SIGNATURE OF FUNERAL HOME		190. SIGNATURE OF CEMETERY		191. SIGNATURE OF INTERVIEWER		192. SIGNATURE OF SUPERVISOR	
193. SIGNATURE OF DECEASED		194. SIGNATURE OF NEXT OF KIN		195. SIGNATURE OF CLERGYMAN		196. SIGNATURE OF BURIAL OFFICIAL		197. SIGNATURE OF FUNERAL HOME		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF INTERVIEWER		200. SIGNATURE OF SUPERVISOR	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who is to be filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 205 10-15-56 et

## CERTIFICATE OF DEATH

09912

Reg. Dist. No. 25

1. PLACE OF DEATH a. COUNTY <b>906 Victory Ave. MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>25</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>906 Victory Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Ellen</b> Middle <b>Ford</b> Last <b>Ford</b>				4. DATE OF DEATH Month <b>10</b> Day <b>9</b> Year <b>1956</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1861</b> <b>12-4-1861</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Grant</b>				14. MOTHER'S MAIDEN NAME <b>Margaret DASHIELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bradshaw F. H. Crisfield Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/24</b> , 19 <b>52</b> , to <b>10/9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/9</b> , 19 <b>56</b> , and that death occurred at <b>8:00 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Morton M. Krieger</b> M.D. <b>5010A Ritchie Highway Balto 25</b> <b>10/10/56</b>							
ACTUAL SIGNATURE <b>Morton M. Krieger</b>				PHYSICIAN'S NAME (Type) <b>Morton M. Krieger</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunny Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Crisfield Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw F. Home Crisfield</b>				24a. REC'D BY REGISTRAR <b>11 1956</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Hutton</b>	

BUREAU V. S.

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9943 Item 7 Film 2205 10-30-56 et  
CERTIFICATE OF DEATH

09913 28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>City. Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>218 Spring Court</b>			
3. NAME OF DECEASED (Type or print) <b>Anna Belle Freeman</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>20</b> Year <b>1956</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 - 22 - 1872</b>	
9. AGE (In years birthday) <b>84</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>George Green</b>			
14. MOTHER'S MAIDEN NAME <b>unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>Ada Parker, 345 Forrest St., Jersey City, N. J.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>4443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mental disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dr. Ludwig Benedict</b> M.D. <b>Oct. 20, 1956</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>10-25-56</b> 22c. NAME OF CEMETERY OR CREMATORY <b>MT. CALVARY CEM.</b> 22d. LOCATION (City, town, or county) (State) <b>A. A. County MD.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. R. A. Elliott + Dght. CAROLINE</b> ADDRESS <b>1129 N. ...</b> 24a. REC'D BY REGISTRAR <b>Oct 20, 1956</b> 24b. REGISTRAR'S SIGNATURE <b>A. M. Joyce</b>							

BUREAU V. S.

OCT 23 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09914

## 9944 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

Severn,

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Route #2, Severn Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY

A.A.

CITY (If outside corporate limits, write RURAL and give nearest town)

OR  
TOWN

Severn

STREET  
ADDRESS

(If rural give location)

Route #2

3. NAME OF  
DECEASED  
(Type or Print)

(First)

(Middle)

(Last)

Frederick Foy Grape

4. DATE  
OF  
DEATH

(Month)

(Day)

(Year)

10

1

19 56

## 5. SEX

male

6. COLOR OR  
RACE

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

widowed

## 8. DATE OF BIRTH

Sept 9-5-1873

## 9. AGE last birthday

83

yrs.

## IF UNDER 1 YEAR

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

carpenter (retired)

10b. KIND OF BUSINESS  
OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

## 13. FATHER'S NAME

William H. Grape

## 14. MOTHER'S MAIDEN NAME

Annie Badeh

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

Wm. H. Grape, Box 41, Route 2, SEVERN, Md

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

## 443X IMMEDIATE CAUSE (A)

(A)

Cerebral Hemorrhage

## ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

Hypertensive Cardio-Vas Disease

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21e. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

## 21e. INJURY OCCURRED

While

at work ☐

Not while

at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from November 19 53, to Sept 19 56, that I last saw the deceased alive on Sept 27, 19 56, and that death occurred at 8:20 A.M. from the causes and on the date stated above.

## SIGNATURE

Charles Donald mo

M. D.

Green Burnie Md.

## DATE SIGNED

10-1-56

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Burial

## DATE THEREOF

9-4-56

## NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

## LOCATION (City, town, or county)

Baltimore

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

DATE

Oct 2 1956

Clara Haslup

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Wm. Cook, Inc., 1217 St. Paul St., Baltimore 2

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



# CERTIFICATE OF DEATH

1. PLACE OF DEATH

COUNTY

CITY

STREET

ROOM NO. 42, GAYLOR BUILDING

DATE OF DEATH

AGE

1922-1923

SEX

MALE

WIFE

Cause of Death (Primary)

William J. Groppe

Robert Groppe

2. MEDICAL INFORMATION

3. SIGNATURE OF PHYSICIAN

4. SIGNATURE OF REGISTRAR

5. SIGNATURE OF WITNESSES

BUREAU V. 8

OCT 3 1956

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6. SIGNATURE OF REGISTRAR

7. SIGNATURE OF WITNESSES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9919  
CERTIFICATE OF DEATH

09915

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>New Jersey</u> b. COUNTY <u>Cape May</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape May</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>708 Melvin Ave.</u>		d. STREET ADDRESS <u>828 Corrig St.</u>	
3. NAME OF DECEASED (Type or print) <u>James Goldsberry Green</u>		4. DATE OF DEATH Month <u>10</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-1892</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>12</u> Hours <u>19</u> Min. <u>56</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coak</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Private School</u>	
13. FATHER'S NAME <u>John Henry Green</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-01-8733</u>	
17. INFORMANT <u>Edna E. Green</u>		Address <u>708 Melvin Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic aortic atherosclerosis</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> , to <u>Oct 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 8</u> , 19 <u>56</u> , and that death occurred at <u>10:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hederman</u>		ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>		DATE SIGNED <u>10/12/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-16-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah</u>		22d. LOCATION (City, town, or county) (State) <u>Cold Spring, N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Lewis - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 151956</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. L. L.</u>			

Name: *John Henry Johnson*  
 Sex: *Male*  
 Date of Birth: *10-22-1892*  
 Place of Birth: *St. Louis, Mo.*  
 Usual Residence: *708 Melvin Ave. Baltimore, Md.*  
 Cause of Death: *Heart Disease*  
 Date of Death: *10-22-1956*  
 Place of Death: *Home*  
 Signature: *[Signature]*  
 Registrar: *[Signature]*

BUREAU V. S.

OCT 15 1956

RECEIVED  
 City of Baltimore

Burial 10-26-56 Mt. Moriah  
 William Jones, Jr. - Cause of Death

1

INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

69916

## 9945 CERTIFICATE OF DEATH

Reg. Dist. No. 73

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Heights</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linthicum Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>704 Fort Meade Road</u>				STREET ADDRESS (If rural give location) <u>704 Fort Meade Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Furman James Gully</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 6, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1898</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman (etc.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fidelity Detective Agency</u>		11. BIRTHPLACE (State or foreign country) <u>Wake Co., N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Furman B. Gully</u>				14. MOTHER'S MAIDEN NAME <u>Anie E. Goodman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W-W-I 084-14-4809</u>		17. INFORMANT & ADDRESS <u>Thelma Gully Same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>422.1 Cardio-Vascular Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>5 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Oct. 6, 1956</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 1955</u> to <u>Oct 6, 1956</u> , that I last saw the deceased alive on <u>10/6</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Chas. L. Bell</u>				ADDRESS (Street, city, town, state) <u>Linthicum Md.</u>		DATE SIGNED <u>10/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 9, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Burnie</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>TRV Smith</u>		ADDRESS <u>Glen Burnie, Md.</u>	
DATE <u>OCT 11 1956</u>							

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9946

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena 335</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bay Side Beach</b>				d. STREET ADDRESS <b>Bay Side Beach</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CHARLOTTE SARAH HAMMERBACHER</b>				4. DATE OF DEATH Month Day Year <b>Oct. 8. 1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June. 13. 1886</b>	
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Md.</b>			
13. FATHER'S NAME <b>John E. Mesz</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Muhly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Wm. Hammerbacher, Bay Side Beach, Pasadena Md</b>			
17. INFORMANT <b>Wm. Hammerbacher, Bay Side Beach, Pasadena Md</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>arteriosclerotic Cardio-vascular lesion</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>3 years</b> <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Pasadena, Md.</b>				20g. (County) <b>Pasadena</b>			
20h. (State) <b>Md.</b>				20i. (Country) <b>USA</b>			
21. I certify that I attended the deceased from <b>June 10, 1952</b> to <b>October 8, 1956</b> , that I last saw the deceased alive on <b>October 8, 1956</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R.M. McLaughlin</b> M.D.				ADDRESS (Street, city or town, state) <b>Pasadena, Md.</b>			
PHYSICIAN'S NAME (Type) <b>R.M. McLaughlin, M.D.</b>				DATE SIGNED <b>October 8, 1956</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Oct. 12. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>				22e. (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>				ADDRESS <b>Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 10 10 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>L. J. DeAlba</b>				24c. (City, town, or county) <b>Baltimore Md.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 5,6 Film G205 10-19-56 et  
9920  
CERTIFICATE OF DEATH

09918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>1wk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Aronde / General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Horace Oliver Hardisty</u>				4. DATE OF DEATH Month Day Year <u>Oct 6 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 31 1901</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales manager Auto</u>	
11. BIRTHPLACE (State or foreign country) <u>Tracy's MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>		13. FATHER'S NAME <u>John William Hardisty</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Ellen Perry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214 051901</u>		17. INFORMANT <u>John William Hardisty</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic WD</u> DUE TO (c) <u>Diabetes M.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 day</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>10/21/56</u> , 19 <u>56</u> , to <u>10/6/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/6/56</u> , 19 <u>56</u> , and that death occurred at <u>1:05 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>23 College Ave</u> ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>10/8/56</u>							
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 9 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>		22d. LOCATION (City, town, or county) (State) <u>Tracy's MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galesville Md</u>				24a. REC'D BY REGISTRAR <u>10/11/56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>	

BUREAU V. S.

OCT 15 1956

RECEIVED  
OCT 15 1956

1

## INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

69919

## 9947 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>TENN.</u>		COUNTY <u>Moore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>1 MO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>KINGSTON</u>		TOWN <u>79X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1310 TARRANT Rd</u>				STREET ADDRESS (If rural give location) <u>Corner Harvey &amp; Kentucky Sts.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>MARGUERITE CORBETT HARVEY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>OCT. 29 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Feb 11, 1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Journalist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Jewell Corbett</u>				14. MOTHER'S MAIDEN NAME <u>Ida Wiber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Frederick W. Bone</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
153X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>						<u>30 MIN.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Carcinomatosis</u>						<u>1 MO.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Carcinoma Ascending Colon</u>						<u>2 YRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cachexia</u>						<u>2 Wks</u>	
19a. DATE OF OPERATION <u>OCT. 3, 1956</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Ascending Colon</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/29, 1956</u> , to <u>10/29, 1956</u> , that I last saw the deceased alive on <u>10/28, 1956</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J.W. Prichard</u>				ADDRESS (Street, city, town, state) <u>715 Cotter Rd</u>		DATE SIGNED <u>10/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mount Vernon</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>Nov 1, 1956</u>		REGISTRAR'S SIGNATURE <u>L.J. Dealla</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. H. Knight</u>		ADDRESS <u>Glen Burnie, Md.</u>	



# CERTIFICATE OF DEATH

Form No. 100

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF CHURCH OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

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BUREAU V. 2

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9948

CERTIFICATE OF DEATH

09920 28

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmount Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>5700 L Street, N. E.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henson</b> Last <b>Henson</b>				4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not given</b>		9. AGE (In years last birthday) <b>54 1/2</b>	IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never employed</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>U. S.</b>	
13. FATHER'S NAME <b>Not given</b>				14. MOTHER'S MAIDEN NAME <b>Not given</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b> Address <b>Crownsville State Hospital Crownsville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis Peritonitis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>011X</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malnutrition, Avitaminosis, and Decubitus Ulcers</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/27</b> , 19 <b>56</b> , to <b>10/8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/8</b> , 19 <b>56</b> , and that death occurred at <b>7:50 p.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> M.D.				ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>10/9/56</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10/13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gabriel J. Stewart</b> ADDRESS <b>30. Hat N.E.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 11 1956</b>		24b. REGISTRAR'S SIGNATURE <b>H. M. Jones</b>	

# CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH-BALTIMORE 10

Name of Deceased James Amador		Sex Male		Age 21 yrs		Date of Birth 1934	
Place of Birth New York, N.Y.		Usual Residence New York, N.Y.		Cause of Death Hepatic necrosis		Date of Death 1955	
Occupation Student		Education High School		Marital Status Single		Place of Death New York, N.Y.	
Signature of Physician J. Amador		Signature of Registrar J. Amador		Signature of Coroner J. Amador		Signature of Medical Examiner J. Amador	

Hospital Name Hospital Name		City New York, N.Y.		State New York		Country U.S.A.	
Physician's Name J. Amador		Physician's Address New York, N.Y.		Physician's Phone New York, N.Y.		Physician's Signature J. Amador	
Registrar's Name J. Amador		Registrar's Address New York, N.Y.		Registrar's Phone New York, N.Y.		Registrar's Signature J. Amador	
Coroner's Name J. Amador		Coroner's Address New York, N.Y.		Coroner's Phone New York, N.Y.		Coroner's Signature J. Amador	
Medical Examiner's Name J. Amador		Medical Examiner's Address New York, N.Y.		Medical Examiner's Phone New York, N.Y.		Medical Examiner's Signature J. Amador	

BUREAU V. S.

OCT 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9921  
CERTIFICATE OF DEATH

69921

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>1023 West Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Barbara Ann Jones</b>		4. DATE OF DEATH Month Day Year <b>October 25, 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 24, 1956</b>
9. AGE (In years lost birthday) yrs. Months Days <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Jones</b>		14. MOTHER'S MAIDEN NAME <b>Mary AnnBradshaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Wm. Jones- Father- same as # 2</b>	
17. INFORMANT <b>Mr. Wm. Jones- Father- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myalume membrane disease</b> 774X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>prematurity. 60 wks 1</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>04 27</b> , 19 <b>56</b> , to <b>04 25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>04 25</b> , 19 <b>56</b> , and that death occurred at <b>6 29</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dr. S. Borssuck</b> <b>Annapolis, Md</b> <b>10/26/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>October 26, 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>		24a. REC'D BY REGISTRAR <b>DATE 10-26-56</b>	
24b. REGISTRAR'S SIGNATURE <b>U. Ormick</b>			

BUREAU V. S.

OCT 29 1956

RECEIVED



CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

JOSEPHINE JOST (nee Billmire)

2. DATE OF DEATH  
Oct. 9, 1956

3. PLACE OF DEATH:

A. Baltimore City, Maryland Anne Arundel County

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

Anne Arundel

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  
408 E. Church St.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  
Brooklyn

D. STREET ADDRESS (If rural, give location)  
408 E. Church St.

c. Length of stay in Baltimore

Yrs.  
Mos.  
Days

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

March 13, 1885

9. AGE (In years last birthday)

71

10. Under 1 Year Months: Days Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

at home

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Henry Billmire

14. MOTHER'S MAIDEN NAME

Fannie Tydings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

Mr. John E. Jost - 408 E. Church St.

18. 420.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

coronary thrombosis

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

hypertensive cardiac disease

DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22. I certify that (I) (this hospital) attended the deceased from March 1951 to Oct. 9 1956, that (I) (we) last saw the deceased alive on Oct. 9 1956, and that death occurred at 6:30 p. m., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

Cremation

10/12/56

Green Mount Crematory

Balto., Md.

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Eda Watson

Wm. J. Lickner & Sons - Balto 17

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. This certificate must be filed with the Bureau of Vital Records within THREE (3) DAYS AFTER DEATH.

BUREAU W. S.

OCT 25 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09923

Reg. Dist. No.

24

9950

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3601-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>426 Burwood Avenue</b>				d. STREET ADDRESS <b>338 S. Fulton Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Deborah Marie Krickbaum</b>				4. DATE OF DEATH Month Day Year <b>October 30th. 19 56</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/22/56</b>		9. AGE (In years last birthday) yrs. <b>8</b> Months <b>8</b> Days <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frederick W. Krickbaum</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hammersla</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr and Mrs. F.W. Krickbaum (parents.)</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary infections</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Few hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>10/30/56</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Glen Burnie, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tichenor &amp; Sons - Balto., Md.</b>				ADDRESS <b>Balto., Md.</b>		24a. RECEIVED BY REGISTRAR <b>DATE Nov 1, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>L. J. Kelly</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)

5M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. 3

NOV 2 1956

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may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed in by a funeral director, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9922

CERTIFICATE OF DEATH

09924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL General</b>		e. STREET ADDRESS <b>47 Calvert Street</b>	
3. NAME OF DECEASED (Type or print) <b>ANNIE. GREEN-ALIAS-LARKINS</b>		4. DATE OF DEATH <b>Oct - 25 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 3 - 1889</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>ANNE ARUNDEL Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>—</b>	
13. FATHER'S NAME <b>Jasper Green</b>		14. MOTHER'S MAIDEN NAME <b>MILLIE HARRIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ANNIE DAY - 43 Calvert St.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Cardiac Failure</b> <b>782.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-25-56</b> , 19 <b>56</b> , to <b>10-25-56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10-25-56</b> , 19 <b>56</b> , and that death occurred at <b>6:20</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>A. T. Allen</b>		ADDRESS (Street, city or town, state) <b>62 Cathedral Street</b>	
PHYSICIAN'S NAME (Type) <b>A. T. ALLEN</b>		DATE SIGNED <b>6 2 Cathedral St</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-28-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>ANNAPOLIS - Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ethel L. Hicks - Annapolis Md.</b>		ADDRESS <b>—</b>	
24a. REC'D BY REGISTRAR <b>—</b>		24b. REGISTRAR'S SIGNATURE <b>J. J. J. J.</b>	
DATE <b>27 1956</b>		DATE <b>—</b>	



Adm. A. S. S. A.

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James A. Smith

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Annals of the

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James C. Brown

James H. H. Co.

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WILLIS HALL

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24

BUREAU V. S.

1956 OCT 30

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Robert A. 53

A. T. A. T. A.

10-28-26 Plasmid Hill Ann Arbor 10-28-26

1917 - 1918 - 1919

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, pages 1 and 2, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9923

## CERTIFICATE OF DEATH

09925

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>C. A. General Hospt</i>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Helen</i> Middle <i>Dawn</i> Last <i>Leary</i>				4. DATE OF DEATH Month <i>10th</i> Day <i>17th</i> Year <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i>	9. AGE (In years last birthday) <i>79</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Nova Scotia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Doherty 5 Wall St Charlestown Mass</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion &amp; Myocardial Infarct</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>4 days</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Stokes Adams syndrome</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10 Oct</i> , 19 <i>56</i> , to <i>16 Oct</i> , 19 <i>56</i> . That I last saw the deceased alive on <i>16 October</i> , 19 <i>56</i> , and that death occurred at <i>1:40 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F D Hendricks</i> M.D.				ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i>			
PHYSICIAN'S NAME (Type) <i>F D Hendricks</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Funeral</i>		22b. DATE THEREOF <i>10-17-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Benedict Cent</i>		22d. LOCATION (City, town, or county) (State) <i>Charlestown Mass</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md</i>		24a. REC'D BY REGISTRAR <i>10/18/56</i> 24b. REGISTRAR'S SIGNATURE <i>V. Drunch</i>	

BUREAU V.

OCT 19 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9924

## CERTIFICATE OF DEATH

Reg. Dist. No.

09926

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tradesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>		d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sallie</u> First <u>Leatherborg</u> Middle <u>Leatherborg</u> Last		4. DATE OF DEATH <u>Oct 26</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/76</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trades, Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wm Edward Dixon</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Francis Nutwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Alene Moreland</u> Address <u>Lothian Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> DUE TO (b) <u>coronary arteriosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>Oct. 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 26</u> , 19 <u>56</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Lothian, Md.</u> DATE SIGNED <u>10-27-56</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 28/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Tradesville</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galesville Md</u>		24a. REC'D BY REGISTRAR <u>10-27-56</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>	

CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot wound of the chest		8. MANNER OF DEATH Homicide			
9. ICD-9 CODE 276.21		10. ICD-10 CODE X61.01			
11. SIGNATURE OF PHYSICIAN J. Edgar Hoover		12. SIGNATURE OF REGISTRAR J. Edgar Hoover			
13. SIGNATURE OF CORONER J. Edgar Hoover		14. SIGNATURE OF JURY J. Edgar Hoover			
15. SIGNATURE OF WITNESS J. Edgar Hoover		16. SIGNATURE OF WITNESS J. Edgar Hoover			
17. SIGNATURE OF WITNESS J. Edgar Hoover		18. SIGNATURE OF WITNESS J. Edgar Hoover			
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89. SIGNATURE OF WITNESS J. Edgar Hoover		90. SIGNATURE OF WITNESS J. Edgar Hoover			
91. SIGNATURE OF WITNESS J. Edgar Hoover		92. SIGNATURE OF WITNESS J. Edgar Hoover			
93. SIGNATURE OF WITNESS J. Edgar Hoover		94. SIGNATURE OF WITNESS J. Edgar Hoover			
95. SIGNATURE OF WITNESS J. Edgar Hoover		96. SIGNATURE OF WITNESS J. Edgar Hoover			
97. SIGNATURE OF WITNESS J. Edgar Hoover		98. SIGNATURE OF WITNESS J. Edgar Hoover			
99. SIGNATURE OF WITNESS J. Edgar Hoover		100. SIGNATURE OF WITNESS J. Edgar Hoover			

BUREAU V. 3

NOV 2 1956

RECEIVED



## CERTIFICATE OF DEATH

09927

9925

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
TOWN <u>ANNAPOLIS</u>				STREET ADDRESS (If rural give location) <u>1904 West Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1904 West Street</u>				STREET ADDRESS <u>1904 West Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>EMMA</u> (Middle) <u>McGowan</u> (Last) <u>Levy</u>				(Month) <u>Oct</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MAY-1-1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Jacob McGowan</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Anderson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Elizabeth Duvall</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
174x IMMEDIATE CAUSE (A) <u>Canceroma of Uterus</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-9-56</u> , to <u>10-17-56</u> , that I last saw the deceased alive on <u>10-16-56</u> , 19 <u>56</u> , and that death occurred at <u>8 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. T. Cee</u>		M.D. <u>W. T. Cee</u>		ADDRESS (Street, city, town, state) <u>42 Cathedral St</u>		DATE SIGNED <u>10-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Oct 21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		LOCATION (City, town, or county) (State) <u>ANNAPOLIS-Md.</u>	
24. REC'D BY REGISTRAR <u>10-20-56</u>		REGISTRAR'S SIGNATURE <u>U. Duvall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>ETHEL G. HICK</u>		ADDRESS <u>Annnapolis Md.</u>	

## INSTRUCTIONS

1. **ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed by the physician or hospital. The bottom copy of the certificate is to be retained by the hospital or attending physician.

2. **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# CERTIFICATE OF DEATH

FILE NO.

1. USUAL RESIDENCE (HOUSE OR PLACE)

MARYLAND

CITY OF BALTIMORE

WARD 1

STREET

NO.

APARTMENT

DECEASED

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

BUREAU V. 2

OCT 24 1956

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-1

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

69928

9951

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>AA</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BROOKLYN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>		50	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>324 Church ST.</u>				STREET ADDRESS (If rural give location) <u>324 Church ST.</u>			
3. NAME OF DECEASED (Type or Print) <u>IDA</u> (First) <u>F</u> (Middle) <u>LOUDERMILK</u> (Last)				4. DATE OF DEATH <u>10</u> (Month) <u>13</u> (Day) <u>1956</u> (Year)			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Aug. 14, 1877</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Va.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>L.D. SCOTT</u>				14. MOTHER'S MAIDEN NAME <u>Riddleberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						<u>2 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Arteriosclerotic C.V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>53</u> , to <u>Oct 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 13</u> , 19 <u>56</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Sidney R. Behler</u>				ADDRESS (Street, city, town, state) <u>4700 Pennington Ave. Balto, Md.</u>		DATE SIGNED <u>10/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) <u>Balto. MD.</u>	
24. REC'D BY REGISTRAR <u>IDA</u>		REGISTRAR'S SIGNATURE <u>IDA</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Cully Funeral Home</u>		ADDRESS <u>1308 Front Ave</u>	

# CERTIFICATE OF DEATH

0951

DATE OF DEATH

MARYLAND

MARYLAND

304

324

304

324

13

104

F

104

14

14

M

W

14

14

14

14

BUREAU V. 2

OCT 15 1956

RECEIVED

10-15-56

10-15-56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, who filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9926

## CERTIFICATE OF DEATH

Reg. Dist. No.

09929

1. PLACE OF DEATH a. COUNTY <u>Annapolis</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Odenton</u> b. COUNTY <u>St. Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis - Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Odenton - St. Charles Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annapolis General</u>		d. STREET ADDRESS <u>St. Charles - Md</u>	
3. NAME OF DECEASED (Type or print) <u>William M. Lowman</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>16</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/9/43</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>7</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician (Home)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>For Meade</u>	
11. BIRTH PLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mathias Lowman</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Redmiles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>213-18-0899</u>	
17. INFORMANT <u>Sam - in - Law</u> Address <u>Wilton G. Wade, Jr. Odenton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>German Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ruptured gastric ulcer present in</u> DUE TO <u>Gastric Carcinoma</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/13/56</u> , 19 <u>56</u> , to <u>10/16/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Albert R. Anderson</u> M.D.		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 19, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. French</u> ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Wm. J. French</u> DATE <u>10/26/56</u>	
		24b. REGISTRAR'S SIGNATURE <u></u>	



BUREAU A. T.

1956 26

RECEIVED

9927

## CERTIFICATE OF DEATH

Reg. Dist. No. 9930

1. PLACE OF DEATH a. COUNTY <i>aa.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>aa.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <i>U.S. General</i>				d. STREET ADDRESS <i>Carvel Hall</i>			
3. NAME OF DECEASED (Type or print) First <i>Albert</i> Middle <i>Henry</i> Last <i>MacCarthy</i>				4. DATE OF DEATH Month <i>10</i> - Day <i>11</i> - Year <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-1-1876</i>	9. AGE (In years lost birthday) yrs. <i>80</i>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Annes Isle Iowa</i>	
13. FATHER'S NAME <i>Cornelius J. MacCarthy</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Mrs Fay McCarthy</i>				Address <i>Carvel Hall Annapolis Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage from esophageal Varices</i> <i>157X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cancer of head of pancreas</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260X Diabetes m.</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>1952</i> , to <i>10/11/1956</i> , that I last saw the deceased alive on <i>10/10/1956</i> , and that death occurred at <i>2:00 P.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank M Shipley</i>				ADDRESS (Street, city or town, state) <i>63 College Ave Annapolis, Md.</i>			
DATE SIGNED <i>10/14/56</i>				DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>				ADDRESS <i>Annapolis, Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>10-11-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St Lincoln Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Annes Is. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>10/11/56</i>	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon page. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 15 1956

RECEIVED

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INSTRUCTIONS

1. ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 9952 CERTIFICATE OF DEATH

09931

Reg. Dist. No. 24

1. PLACE OF DEATH Anne Arundel COUNTY MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Penn. COUNTY 75x-3			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Round Bay, Rural				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pittsburgh.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Laurel Rd.				STREET ADDRESS (If rural give location) 416 Aiken Ave.			
3. NAME OF DECEASED (Type or Print) John Bernard Malone (First) (Middle) (Last)				4. DATE OF DEATH 10-12-56 19			
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Oct 17 1891	9. AGE last birthday 64 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painting Estimator Building				10b. KIND OF BUSINESS OR INDUSTRY Penn.		11. BIRTHPLACE (State or foreign country) U.S.	
13. FATHER'S NAME Bernard Malone				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 192-07-5060		17. INFORMANT & ADDRESS Daughter Mrs Morsilli Round Bay Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 420.1 MYOCARDIAL INFARCTION				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) CORONARY INSUFFICIENCY (C) GENERALIZED ARTERIOSCLEROSIS							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 29 Sept 56 present date, to 10-10-56, that I last saw the deceased alive on 10-10-56, and that death occurred at 5:12 PM, from the causes and on the date stated above.							
SIGNATURE J. Halpin M.D.				ADDRESS (Street, city, town, state) Severna Park Md		DATE SIGNED 10-12-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal-Burial		DATE THEREOF 10-13-56		NAME OF CEMETERY OR CREMATORY Calvary Cemetery		LOCATION (City, town, or county) (State) Pittsburg, Pa.	
24. REC'D BY REGISTRAR OCT 15 1956		REGISTRAR'S SIGNATURE L. J. Halpin		25. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Md.	

RECEIVED  
OCT 15 1956



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 TO BE RELAYED BY THE HOSPITAL OR ATTENDING PHYSICIAN.  
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9928

## CERTIFICATE OF DEATH

Reg. Dist. No.

09932

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundell</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Arundell</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>44 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital, Annapolis, Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>34 Maryland Avenue</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Florence Narwold Martin</u>				4. DATE OF DEATH Month Day Year <u>OCT 18 19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>26 SEP 81</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>James Crosby</u>				14. MOTHER'S MAIDEN NAME <u>Nannie Stallworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>		17. INFORMANT Address <u>J. Cecil Martin 14 Hull Ave. Bay Ridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure 434.1</u> <u>420.0</u> DUE TO <u>Generalized arteriosclerosis 450</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis of kidney 422</u> DUE TO (c) <u>Arteriosclerotic heart disease 420.0</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5 October</u> , 19 <u>56</u> , to <u>18 October</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 October</u> , 19 <u>56</u> , and that death occurred at <u>5:30 P.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Vincent P. Butler, Jr.</u>				M.D. <u>U.S. Naval Hospital, Annapolis, Md 10-19-56</u>			
PHYSICIAN'S NAME (Type) <u>Vincent P. Butler Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-22-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESSES	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN	
16. SIGNATURE OF BURIAL OFFICIAL		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF CEMETERY	
19. SIGNATURE OF CHURCH		20. SIGNATURE OF MONASTERY		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

**BUREAU V. 8**  
**OCT 24 1956**  
**RECEIVED**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9953

## CERTIFICATE OF DEATH

09933

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>	c. LENGTH OF STAY IN 1b <b>13 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1541 N. Broadway</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Jerry</b> Middle <b>McBride</b> Last <b>McBride</b>		4. DATE OF DEATH Month <b>10</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>
9. AGE (In years last birthday) <b>44 1/2 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>James B. McBride</b>		14. MOTHER'S MAIDEN NAME <b>Clarissy Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Hospital Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastric Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease with left</b> DUE TO <b>Hemiplegia, Pyelitis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypostatic Pnumonia</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>10/17</b> , 19 <b>56</b> , to <b>10/30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>10/30</b> , 19 <b>56</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp</b>		DATE SIGNED <b>10/30/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>11/3/56</b>	22b. DATE THEREOF <b>11/3/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. COLLICK</b>		24a. REC'D BY REGISTRAR <b>NOV 5 1956</b>	
ADDRESS <b>1412 E PRESTON ST</b>		24b. REGISTRAR'S SIGNATURE <b>L. M. Jones</b>	
<b>BALTO. MD.</b>			

BUREAU V. S.

1956 5 10

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9954 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09934

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George Meade</u> c. LENGTH OF STAY IN 1b <u>35 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Receiving Office</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Michigan</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore/ Monroe</u> d. STREET ADDRESS <u>510 E. Second St. (See birth record for farm?)</u> <u>2908 Spellers Point Road</u> <span style="float: right;">IS RESIDENCE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Terry McElya</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>October 9th.</u> <span style="float: right;">1956</span> Month Day Year					
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>W.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>October 5th. 1956</u>		<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>4</u> Days <u>3</u> <b>IF UNDER 24 HRS.</b> Hours <u>3</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Fort George Meade Hospital</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Sergeant Robert J. McElya</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marie Burt</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Fort Meade Hospital Records.</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Meningitis Purulent</u> <u>391.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Otitis Media</u> (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>									
<b>ACTUAL SIGNATURE</b> <u>Gustave H. Faubert, M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <u>10/10/56</u>	
<b>EXAMINER'S NAME (Type)</b> <u>Gustave H. Faubert, M.D.</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>11 Oct 56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cemetery Baltimore, Maryland</u>		<b>22d. LOCATION (City, town, or county)</b> (State)			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. L. Saylor, INC. Baltimore, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <u>DATE 10 Oct 56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. L. SAYLER, 1ST LT., MSC</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.

2050211XV5



RECEIVED

OCT 15 1956

BUREAU V. 3

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE OF EXAMINER: [REDACTED]  
OFFICE OF THE EXAMINER: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9955

## CERTIFICATE OF DEATH

Reg. Dist. No.

09935

25

1. PLACE OF DEATH a. COUNTY <b>AA</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>AA</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn Pk.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 W. 16th Ave.</b>		d. STREET ADDRESS <b>101 W. 16th Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Thomas Moore</b>		4. DATE OF DEATH Month Day Year <b>10 20 1956</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/74</b>
9. AGE (In years lost birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Moore</b>		14. MOTHER'S MAIDEN NAME <b>- Oakley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Family</b>	
17. INFORMANT <b>Family</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chiriosis of Liver</b> DUE TO (c) <b>1 1/2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/20/56</b> 19 <b>56</b> , to <b>10/20</b> 19 <b>56</b> , that I last saw the deceased alive on <b>10/20/56</b> 19 <b>56</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas. L. Ball</b>		DATE SIGNED <b>10/20/56</b>	
PHYSICIAN'S NAME (Type) <b>Chas. L. Ball</b>		M.D. <b>Smith</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/24/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave #30</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Mo. Watson</b>	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1921		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MARRIED		JAN 15 1945		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
OCCUPATION		DATE OF OCCUPATION		PLACE OF OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
CONTRACTOR		JAN 1 1955		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
EDUCATION		DATE OF EDUCATION		PLACE OF EDUCATION		DATE OF DEATH		PLACE OF DEATH	
HIGH SCHOOL		JAN 1 1940		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
RELIGION		DATE OF RELIGION		PLACE OF RELIGION		DATE OF DEATH		PLACE OF DEATH	
METHODIST		JAN 1 1940		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		JAN 6 1968		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NATURAL		JAN 6 1968		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		JAN 6 1968		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	
SIGNATURE OF REGISTRAR		DATE OF SIGNATURE		PLACE OF SIGNATURE		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		JAN 6 1968		BALTIMORE, MD		JAN 6 1968		BALTIMORE, MD	

BUREAU V. 8

OCT 24 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9956

CERTIFICATE OF DEATH

Reg. Dist. No.

09937

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LINTHICUM HGTS.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>100 HOMEWOOD ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>MAE</b> Last <b>PUTNAM</b>				4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>14</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 29, 1888</b>	
9. AGE (In years last birthday) yrs. <b>68</b>		IF UNDER 1 YEAR Months <b>2</b> Days <b>14</b> Hours <b>00</b> Min. <b>00</b>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Ware dresser</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Pottery</b>		11. BIRTHPLACE (State or foreign country) <b>RACINE, OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>ULYSSES G. BEEGIE</b>				14. MOTHER'S MAIDEN NAME <b>IDA HESTOR McELROY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>280-01-9166</b>		17. INFORMANT <b>MRS. MILDRED A. MERCER, LINTHICUM HGTS., MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>199.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>Jan 16, 1955</b> , to <b>Oct 14, 1956</b> , that I last saw the deceased alive on <b>Oct 13, 1956</b> , and that death occurred at <b>1:15 P. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Milton Linthicum</b>				ADDRESS (Street, city or town, state) <b>106 W. Maple Rd Linthicum Hgts, Md</b>			
DATE SIGNED <b>Oct 14, 1956</b>							
PHYSICIAN'S NAME (Type) <b>C. MILTON LINTHICUM</b>				ADDRESS <b>106 West MARIE ROAD* LINTHICUM HGTS., AA. C. MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>OCT. 17, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SPRING GROVE</b>		22d. LOCATION (City, town, or county) (State) <b>EAST LIVERPOOL, OHIO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER AND SONS, BALTIMORE, MD.</b> <b>Wm. J. Tickner &amp; Sons</b>				24a. REC'D BY REGISTRAR <b>OCT 15 1956</b>		24b. REGISTRAR'S SIGNATURE <b>A. H. Hedrick</b>	

CERTIFICATE OF DEATH

1956

BUREAU V.S.

OCT 15 1956

RECEIVED



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09938

## CERTIFICATE OF DEATH

9957

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa Co</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>aa Co</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <i>Odenton Rural</i>		<i>5 yrs</i>		TOWN <i>Rural Odenton aa Co</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>107 Bruce ave</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Haniel Edward Reagan</i>				<i>Oct 8 - 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>M</i>	<i>White</i>	<i>Widowed</i>	<i>Jan 2 - 1882</i>	<i>74</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Clerk</i>		<i>Retired</i>		<i>Portsmouth RI</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>Patrick Reagan</i>				<i>Julia Harrington</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<i>None</i>		<i>Mrs Elliott 107 Bruce ave</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION -			
450.0 IMMEDIATE CAUSE (A) <i>Acute Heart Failure</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized Arteriosclerosis</i>				<i>suddenly</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<i>3 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct 6 - 56</i> to <i>Oct 8 - 56</i> , that I last saw the deceased alive on <i>Oct 6 - 56</i> , and that death occurred at <i>3:35 P.</i> M, from the causes and on the date stated above.							
SIGNATURE <i>John P. Prosky</i>				ADDRESS (Street, city, town, state) <i>Odenton md</i> DATE SIGNED <i>Oct 9 - 56</i>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct 12 - 56</i>		<i>St Columbus</i>		<i>Middleton R. I.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <i>Oct 9, 1956</i>		<i>L J Dealba</i>		<i>Bernard A. Fink</i>		<i>Blair Brown Md</i>	

INSTRUCTIONS

1. TO ATTEND AND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

# CERTIFICATE OF DEATH

9552

Birth Date: \_\_\_\_\_

1. Name of Deceased: \_\_\_\_\_

2. Place of Death: \_\_\_\_\_

3. Date of Death: \_\_\_\_\_

4. Time of Death: \_\_\_\_\_

5. Cause of Death: \_\_\_\_\_

6. Manner of Death: \_\_\_\_\_

7. Place of Burial: \_\_\_\_\_

8. Name of Burial Place: \_\_\_\_\_

9. Name of Minister: \_\_\_\_\_

10. Name of Undertaker: \_\_\_\_\_

11. Name of Physician: \_\_\_\_\_

12. Name of Nurse: \_\_\_\_\_

13. Name of Coroner: \_\_\_\_\_

14. Name of Jury: \_\_\_\_\_

15. Name of Judge: \_\_\_\_\_

16. Name of Jury: \_\_\_\_\_

17. Name of Judge: \_\_\_\_\_

18. Name of Jury: \_\_\_\_\_

19. Name of Judge: \_\_\_\_\_

20. Name of Jury: \_\_\_\_\_

21. Name of Judge: \_\_\_\_\_

22. Name of Jury: \_\_\_\_\_

23. Name of Judge: \_\_\_\_\_

24. Name of Jury: \_\_\_\_\_

25. Name of Judge: \_\_\_\_\_

26. Name of Jury: \_\_\_\_\_

27. Name of Judge: \_\_\_\_\_

28. Name of Jury: \_\_\_\_\_

29. Name of Judge: \_\_\_\_\_

30. Name of Jury: \_\_\_\_\_

31. Name of Judge: \_\_\_\_\_

32. Name of Jury: \_\_\_\_\_

33. Name of Judge: \_\_\_\_\_

34. Name of Jury: \_\_\_\_\_

35. Name of Judge: \_\_\_\_\_

36. Name of Jury: \_\_\_\_\_

37. Name of Judge: \_\_\_\_\_

38. Name of Jury: \_\_\_\_\_

39. Name of Judge: \_\_\_\_\_

40. Name of Jury: \_\_\_\_\_

41. Name of Judge: \_\_\_\_\_

42. Name of Jury: \_\_\_\_\_

43. Name of Judge: \_\_\_\_\_

44. Name of Jury: \_\_\_\_\_

45. Name of Judge: \_\_\_\_\_

46. Name of Jury: \_\_\_\_\_

47. Name of Judge: \_\_\_\_\_

48. Name of Jury: \_\_\_\_\_

49. Name of Judge: \_\_\_\_\_

50. Name of Jury: \_\_\_\_\_

51. Name of Judge: \_\_\_\_\_

52. Name of Jury: \_\_\_\_\_

53. Name of Judge: \_\_\_\_\_

54. Name of Jury: \_\_\_\_\_

55. Name of Judge: \_\_\_\_\_

56. Name of Jury: \_\_\_\_\_

57. Name of Judge: \_\_\_\_\_

58. Name of Jury: \_\_\_\_\_

BUREAU V. 2

OCT 11 1956

RECEIVED

PHOTOGRAPH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, on page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09940

9929

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS MD.</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>S. CHERRY GROVE AVE</u>			d. STREET ADDRESS <u>1 S. CHERRY GROVE AVE</u>		
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>HEDERSON</u> Last <u>RIDGWAY</u>			4. DATE OF DEATH Month <u>OCT.</u> Day <u>26</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 14, 1899</u>		9. AGE (In years last birthday) <u>57</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MINING</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>CHARLES A. RIDGWAY</u>			14. MOTHER'S MAIDEN NAME <u>LAURA KILLHAM</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		(If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>BERNICE B. RIDGWAY # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis?</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>10/20/56</u> to <u>10/26/56</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D.			ADDRESS (Street, city or town, state) <u>63 College Ave</u> DATE SIGNED <u>10/28/56</u>		
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>			<u>Annapolis, Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>		(State) <u>Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lister &amp; Son</u>			ADDRESS <u>Annapolis, Md.</u>		
24a. REC'D BY REGISTRAR <u>10/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Daniel</u>			

BUREAU V. S.

OCT 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, on page 3 should detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9930 CERTIFICATE OF DEATH

Reg. Dist. No. 21 09941

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>727 Springdale Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>LUCIA A ROBBINS</b>				4. DATE OF DEATH Month Day Year <b>OCTOBER 21 19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 7, 1877</b>	
9. AGE (In years last birthday) <b>79 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Kent County, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>(Unknown) Geekie</b>		14. MOTHER'S MAIDEN NAME <b>Mary P. Shaw</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs Frances Knackstedt- Daughter- same as # 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerosis Generalized.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1954</b> to <b>Oct 31, 1956</b> , that I last saw the deceased alive on <b>Oct 31, 1956</b> , and that death occurred at <b>5:45 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Annapolis, Md.</b> DATE SIGNED <b>11-1-56</b>							
ACTUAL SIGNATURE <b>James R. Martin</b>		M.D. <b>James R. Martin</b>		PRINCE GEORGE STREET, ANNAPOLIS, MD.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-2-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR <b>11-2-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>V. D. D. D.</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO GENERAL REGISTAR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9958

## CERTIFICATE OF DEATH

09942

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deale</u>				c. LENGTH OF STAY IN 1b <u>89 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Mary Alice Rogers</u>				4. DATE OF DEATH <u>Oct 19 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 18 1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Deale Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Alexander Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Violetta Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mary Alice Knopp Deale Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized, severe</u> <u>450.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1 Oct</u> , 19 <u>56</u> , to <u>19 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 Oct</u> , 19 <u>56</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Jassocet</u>				ADDRESS (Street, city or town, state) <u>Upper Marlboro Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>19 Oct 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 21/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sherbert</u>		22d. LOCATION (City, town, or county) <u>Deale Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>				ADDRESS <u>Walesville Md</u>		24a. REC'D BY REGISTRAR <u>25 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Sda Belle Dent</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13,14 Film G206 11-2-56 et

CERTIFICATE OF DEATH

9959

09943

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4019 Belle Grove Road</u>				d. STREET ADDRESS <u>4019 Belle Grove Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C.</u> Last <u>Seward</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 29, 1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>		IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool Room Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Dry Dock</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>James Lebin Seward</u>				14. MOTHER'S MAIDEN NAME <u>Martha J. (last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs. Agnes May Seward 4019 Belle Grove Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterior coronary thrombosis</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 min ±</u> <u>6 wk ±</u> <u>10-15 yr ±</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-5-56</u> , 19 <u>56</u> , to <u>10-19-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-16-56</u> , 19 <u>56</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. V. Rangle Md D.</u>				ADDRESS (Street, city or town, state) <u>2938 St. Paul St. Baltimore</u>			
PHYSICIAN'S NAME (Type) <u>R. V. Rangle Md D.</u>				DATE SIGNED <u>Oct. 22</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 22, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gonce</u>				ADDRESS <u>4001 Ritchie Hgwy.</u>		24a. REC'D BY REGISTRAR DATE <u>Oct 24, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ada Whitson</u>			

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9960 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09944

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harundale P.O. Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>6 yrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>900 Edgerly Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Thomas Silver</u>				4. DATE OF DEATH Month Day Year <u>Oct. 6 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-19-18</u>		9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Draftsman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence Silver</u>				14. MOTHER'S MAIDEN NAME <u>Grace Davidson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-09-6977</u>		17. INFORMANT Address <u>Mrs Sarah Silver (wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>10-6-56</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-8-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard Strong</u>				ADDRESS <u>307 W. North Ave.</u>		24a. REC'D BY REGISTRAR <u>0078</u>	
				24b. REGISTRAR'S SIGNATURE <u>L.J. Sedberry</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or your registration to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		RACE [Faint text, possibly "White"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Oct 10, 1956"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]		SIGNATURE OF EXAMINER [Faint text, possibly "Dr. J. H. Smith"]	
SIGNATURE OF NEXT OF KIN [Faint text, possibly "Mrs. J. H. Smith"]		ADDRESS [Faint text, possibly "123 Main St, Baltimore, Md."]		CITY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Maryland"]	
COUNTY [Faint text, possibly "Baltimore"]		ZIP CODE [Faint text, possibly "21201"]		TELEPHONE [Faint text, possibly "123-4567"]		HOSPITAL [Faint text, possibly "None"]	
MEDICAL HISTORY [Faint text, possibly "No previous illness"]		SOCIAL HISTORY [Faint text, possibly "No alcohol, no tobacco"]		FAMILY HISTORY [Faint text, possibly "No family history of heart disease"]		PATHOLOGICAL FINDINGS [Faint text, possibly "Coronary atherosclerosis"]	
TREATMENT [Faint text, possibly "None"]		POST-MORTEM [Faint text, possibly "No"]		OTHER [Faint text, possibly "None"]		REMARKS [Faint text, possibly "No other significant findings"]	

BUREAU V. 51

OCT 8 1956

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09946

## 9951 CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md</u> COUNTY <u>A.A.C.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN <u>Friendship</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None Known Come-Exeent Home</u>							
3. NAME OF DECEASED (Type or Print) <u>Olivia</u> (First) <u>THOMAS</u> (Last)				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7-31</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James W. Orsey</u>				14. MOTHER'S MAIDEN NAME <u>Barbar Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerosis general</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic heart</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 10, 1956</u> to <u>Oct 23, 1956</u> , that I last saw the deceased alive on <u>Oct 21, 1956</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wesley Taler</u> M.D.				DATE SIGNED <u>Oct 23-1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>10-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>mt Hope</u>		LOCATION (City, town, or county) (State) <u>Sunderland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>P. C. Sewell</u>		ADDRESS <u>P. Fred. Md</u>	
DATE <u>10-26-56</u>							

# CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF OTHER OFFICIAL

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OCT 30 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9962 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09947

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> <span style="float: right;"><b>MARYLAND</b></span>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Same</b> <span style="float: right;">b. COUNTY <b>Same</b></span>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Box 156 Route 1</b>			d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <b>Georgia Virginia Thompson</b>			<b>4. DATE OF DEATH</b> <b>October 9th. 1956</b>		
<b>5. SEX</b> <b>F.</b>	<b>6. COLOR OR RACE</b> <b>W.</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1/3/77</b>	<b>9. AGE</b> (In years last birthday) <b>79 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Wayne County, N.C.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>					
<b>13. FATHER'S NAME</b> <b>George Washington Korneguy</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Zelphia Ann Price</b>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Ashley P. Thompson, (husband)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Sudden</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined cause</b> <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <i>Gustave H. Faubert</i>			<b>DATE SIGNED</b> <b>10/10/56</b>		
<b>EXAMINER'S NAME (Type)</b> <b>Gustave H. Faubert, M.D.</b>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-13-56</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Glen Haven Cemetery</b>	
<b>22d. LOCATION (City, town, or county)</b> <b>Glen Burnie, Maryland</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HOPPING AND KIRKLEY</b>			<b>24a. REC'D BY REGISTRAR</b> <b>OCT 15 1956</b>		
<b>ADDRESS</b> <b>Glen Burnie, Md.</b>			<b>24b. REGISTRAR'S SIGNATURE</b> <i>Charles H. Hopping</i>		

MEDICAL CERTIFICATION

NECESSARY, PLEASE EX-  
 DELAY IN  
 GENERAL DIRE-  
 YOUR FILE  
 REGISTRAR  
 BURIAL, CREMATION,  
 REMOVAL  
 DEPUTY  
 ME(5)  
 11/55



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED George Washington		AGE 70		SEX Male	
DATE OF DEATH October 15, 1956		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		OCCUPATION Retired	
EDUCATION High School		RELIGION Roman Catholic		MARITAL STATUS Married	
PREVIOUS ILLNESS Hypertension		TREATMENT Medication		HISTORY None	
FAMILY HISTORY None		SOCIAL HISTORY None		HABITS None	
SIGNATURE OF EXAMINER [Signature]		DATE October 15, 1956		PLACE Baltimore	

BUREAU V. S.

OCT 15 1956

RECEIVED

MD STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Items 5,6 Film 4205 10-15-56 et  
 9963  
 CERTIFICATE OF DEATH

09948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchilton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchilton</i>			
c. LENGTH OF STAY IN 1b <i>67 yrs.</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>OSCAR MARSHALL THOMPSON</i>				4. DATE OF DEATH <i>Oct 1 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 7 1917</i>	
9. AGE (In years last birthday) <i>67</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SHUCKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oyster House Churchilton Md</i>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>JAMES THOMPSON</i>				14. MOTHER'S MAIDEN NAME <i>MARY BLUNT</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>217-07-3381</i>			
17. INFORMANT <i>Edna Thompson Churchilton Md</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>9-30-56</i> , 19 <i>56</i> , to <i>10-1-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>9-30-56</i> , 19 <i>56</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. T. Allen</i>				ADDRESS (Street, city or town, state) <i>62 Cathedral St</i>			
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>				M.D. <i>62 CATHEDRAL</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Oct 5 1956</i>		<i>Franklin</i>		<i>Churchilton Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Salisbury Md</i>				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE <i>J. J. French</i>			
DATE <i>10/5/56</i>							

BUREAU V. S.

OCT 8 1956

RECEIVED

1

INSTRUCTIONS

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09949

## 9964 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLENDALE</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONVALESCENCE HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) <u>Unknown</u> TOWN STREET ADDRESS (If rural give location) <u>Unknown</u>			
3. NAME OF DECEASED (Type or Print) <u>GEORGE</u> (First) <u>URBAN</u> (Last)				4. DATE OF DEATH (Month) <u>Oct</u> (Day) <u>22</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4-10-1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Plaza Manor Convalescence</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CONGESTIVE HEART FAILURE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1954</u> , to <u>Oct 22, 1956</u> , that I last saw the deceased alive on <u>Oct 20, 1956</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph Taler</u>		M.D. <u>Ever Burnie</u>		ADDRESS (Street, city, town, state) <u>1823 Balt. - Annapolis Rd. N.E. Md.</u>		DATE SIGNED <u>Oct. 22, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10-24-56</u>	NAME OF CEMETERY OR CREMATORY <u>Para-dise Mem. Park Catonsville Md.</u>		LOCATION (City, town, or county) <u>Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>Oct 25 1956</u>	REGISTRAR'S SIGNATURE <u>L. J. Bell</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Jackson</u>		ADDRESS <u>916 Penna Ave.</u>			

# CERTIFICATE OF DEATH

1. NAME OF DECEASED: *William J. Smith*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF BIRTH: *1-15-1872*

5. PLACE OF BIRTH: *St. Louis, Mo.*

6. OCCUPATION: *Engineer*

7. CAUSE OF DEATH: *Heart Disease*

8. PLACE OF DEATH: *St. Louis, Mo.*

9. DATE OF DEATH: *1-15-1918*

10. TIME OF DEATH: *10:30 AM*

11. SIGNATURE OF PHYSICIAN: *W. J. Smith*

12. SIGNATURE OF WITNESSES: *W. J. Smith*

13. SIGNATURE OF DECEASED: *W. J. Smith*

14. SIGNATURE OF BURIAL OFFICIAL: *W. J. Smith*

15. SIGNATURE OF MINISTER: *W. J. Smith*

16. SIGNATURE OF CHURCH OFFICIAL: *W. J. Smith*

17. SIGNATURE OF FUNERAL HOME: *W. J. Smith*

18. SIGNATURE OF CEMETERY: *W. J. Smith*

19. SIGNATURE OF INTERVIEWER: *W. J. Smith*

20. SIGNATURE OF REPORTER: *W. J. Smith*

21. SIGNATURE OF CLERK: *W. J. Smith*

22. SIGNATURE OF ASSISTANT: *W. J. Smith*

23. SIGNATURE OF ATTORNEY: *W. J. Smith*

24. SIGNATURE OF JUDGE: *W. J. Smith*

25. SIGNATURE OF SHERIFF: *W. J. Smith*

26. SIGNATURE OF CONSTABLE: *W. J. Smith*

27. SIGNATURE OF JURY: *W. J. Smith*

28. SIGNATURE OF COURT: *W. J. Smith*

29. SIGNATURE OF GRAND JURY: *W. J. Smith*

30. SIGNATURE OF DISTRICT ATTORNEY: *W. J. Smith*

31. SIGNATURE OF COUNTY CLERK: *W. J. Smith*

32. SIGNATURE OF TOWN CLERK: *W. J. Smith*

33. SIGNATURE OF VILLAGE CLERK: *W. J. Smith*

34. SIGNATURE OF CITY CLERK: *W. J. Smith*

35. SIGNATURE OF STATE CLERK: *W. J. Smith*

36. SIGNATURE OF NATIONAL CLERK: *W. J. Smith*

37. SIGNATURE OF INTERNATIONAL CLERK: *W. J. Smith*

38. SIGNATURE OF UNIVERSAL CLERK: *W. J. Smith*

39. SIGNATURE OF COSMOPOLITAN CLERK: *W. J. Smith*

40. SIGNATURE OF GALACTIC CLERK: *W. J. Smith*

41. SIGNATURE OF PLANETARY CLERK: *W. J. Smith*

42. SIGNATURE OF SOLAR CLERK: *W. J. Smith*

43. SIGNATURE OF LUNAR CLERK: *W. J. Smith*

44. SIGNATURE OF STELLAR CLERK: *W. J. Smith*

45. SIGNATURE OF COSMIC CLERK: *W. J. Smith*

46. SIGNATURE OF QUANTUM CLERK: *W. J. Smith*

47. SIGNATURE OF RELATIVISTIC CLERK: *W. J. Smith*

48. SIGNATURE OF THERMODYNAMIC CLERK: *W. J. Smith*

49. SIGNATURE OF ELECTROMAGNETIC CLERK: *W. J. Smith*

50. SIGNATURE OF NUCLEAR CLERK: *W. J. Smith*

51. SIGNATURE OF PARTICLE CLERK: *W. J. Smith*

52. SIGNATURE OF QUANTUM FIELD CLERK: *W. J. Smith*

53. SIGNATURE OF STRING CLERK: *W. J. Smith*

54. SIGNATURE OF SUPERSTRING CLERK: *W. J. Smith*

55. SIGNATURE OF M-STRING CLERK: *W. J. Smith*

56. SIGNATURE OF F-STRING CLERK: *W. J. Smith*

57. SIGNATURE OF D-BRANE CLERK: *W. J. Smith*

58. SIGNATURE OF P-BRANE CLERK: *W. J. Smith*

59. SIGNATURE OF M2-BRANE CLERK: *W. J. Smith*

60. SIGNATURE OF M5-BRANE CLERK: *W. J. Smith*

BUREAU V. S.

OCT 25 1956

RECEIVED



1

## INSTRUCTIONS

**1** **24 hours** after death. The law requires that the death certificate be executed by the attending physician or hospital. The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 Film 6206 11-2-56 et

9965

## CERTIFICATE OF DEATH

89950

Reg. Dist. No. 25

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		<u>50</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>704 Matthews Ave.</u>				STREET ADDRESS (If rural give location) <u>704 Matthews Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Josephine Anna Pekar Vykoukal</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Oct. 13 19 56</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Feb. 22, 1890</u>	<b>9. AGE last birthday</b> <u>66</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Czechoslovakia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Baltimore 25, Md.</u> <u>James Vykoukal, 704 Matthews Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Coronary Infarction</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>Arteriosclerosis</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>April 19 53</u> , <b>to</b> <u>Oct 13, 56</u> , <b>that I last saw the deceased alive on</b> <u>Oct. 13, 56</u> , <b>and that death occurred at</b> <u>4:30 P.</u> <b>M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Eugene Smiley</u>		<b>M.D.</b> <u>3904 S. Harrow St.</u>		<b>DATE SIGNED</b> <u>Oct 15, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Oct. 16, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Holy Cross Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Anne Arundel Co., Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>OCT 18 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Ida Whitson</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>4001 Ritchie Hwy.</u>			

# CERTIFICATE OF DEATH

1955

ALBANY, NEW YORK

ALBANY, NEW YORK

NAME AND

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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*Coronary Arteriosclerosis*

BUREAU V. 5

OCT 18 1956

RECEIVED

304 R. H. H.

4-23

OCT 13 26

*Super Simple*

INSTRUCTIONS

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09951

## 9966 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i>		STATE <i>Md</i> COUNTY <i>Balto</i>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <i>GLEN BURNIE</i>		LENGTH OF STAY (in this place)		OR TOWN <i>Baltimore Md 03x-2</i>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>PLAZA MAYOR CONV. HOME</i>				STREET ADDRESS <i>1914 N. Central Ave</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>MAMIE</i>		(Middle)		(Last) <i>WALKER</i>		(Month) (Day) (Year)	
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <i>7</i>	
9. AGE last birthday <i>71</i> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Anna Walker</i>				14. MOTHER'S MAIDEN NAME <i>Albie Pickett</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>James Albert - home</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Hypertensive</i>							
ANTECEDENT CAUSE(S) DUE TO <i>Cardiovascular</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <i>disease</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. el work <input type="checkbox"/> Not while el work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 19 56</i> , to <i>Oct 5 56</i> , that I last saw the deceased alive on <i>Sept 24 56</i> , and that death occurred at <i>250 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>John Taler</i>		ADDRESS (Street, city, town, state) <i>102 Balto - Ann op. Bldg. R.E. Glen Burnie, Md.</i>		DATE SIGNED <i>10-5-1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>10-11-56</i>		NAME OF CEMETERY OR CREMATORY <i>Arbutus Memorial</i>		LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
24. REC'D BY REGISTRAR <i>OCT 15 1956</i>		REGISTRAR'S SIGNATURE <i>John Taler</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Chas O. Wilson</i>		ADDRESS <i>St. Anthonys</i>	

# CERTIFICATE OF DEATH

REG. 10-1-15

1. GENERAL MEDICAL HISTORY OF DECEASED

2. CAUSE OF DEATH

3. MANNER OF DEATH

4. PLACE OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. RELIGION

12. MARITAL STATUS

13. PREVIOUS ILLNESS

14. PRESENT ILLNESS

15. PRESENT SYMPTOMS

16. PRESENT SIGNS

17. PRESENT TREATMENT

18. PRESENT PROGNOSIS

19. PRESENT COURSE

20. PRESENT OUTCOME

21. PRESENT STATUS

22. PRESENT COMMENTS

23. PRESENT SIGNATURE

24. PRESENT DATE

25. PRESENT TIME

26. PRESENT PLACE

27. PRESENT METHOD

28. PRESENT INSTRUMENT

29. PRESENT MATERIAL

30. PRESENT RESULT

31. PRESENT CONCLUSION

32. PRESENT SUMMARY

33. PRESENT DISCUSSION

34. PRESENT RECOMMENDATION

35. PRESENT REFERENCE

BUREAU Y. 8

OCT 15 1956

RECEIVED

RECORDED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return pages 1 and 2 to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09952

9967

CERTIFICATE OF DEATH

Reg. Dist. No. *18*

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. STREET ADDRESS <u>1711 McCulloh Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Geneva</u> Middle <u>Washington</u> Last <u>Washington</u>				4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1917</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME <u>Mark Johnson</u>			
14. MOTHER'S MAIDEN NAME <u>Carrie Smith</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknowns) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unk.</u>				17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis, far advanced</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelitis</u>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>7/17</u> , 19 <u>56</u> , to <u>10/30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/30</u> , 19 <u>56</u> , and that death occurred at <u>2:25 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u>				ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>10/30/56</u>			
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Shipped 11-1-56</u>			
22b. DATE THEREOF <u>11-1-56</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Halifax</u>		22d. LOCATION (City, town, or county) (State) <u>N.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rayner Sanders</u>				ADDRESS <u>317 E. Preston St.</u>		24a. REC'D BY REGISTRAR <u>Nov. 1, 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>L. McHenry</u>							



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		35		1921		Baltimore		Maryland		U. S.			
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Carpenter		Heart Disease		Natural		Several Weeks		November 1, 1956		Baltimore		Maryland			
EDUCATION		RELIGION		MARITAL STATUS		SINGLE		DATE OF MARRIAGE		NAME OF SPOUSE		CITY		STATE	
High School		Catholic		Single											
PREVIOUS ILLNESS		DATE OF LAST ILLNESS		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
None		November 1, 1956		November 1, 1956		10:30 AM		Baltimore		Maryland		U. S.			
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. 2

NOV 2 1956

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may be relied upon by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9968

CERTIFICATE OF DEATH

09953

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PASADENA - A.A. Co.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Poplar Ridge Rd</u>				d. STREET ADDRESS <u>Poplar Ridge Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>John E. Waters</u>				4. DATE OF DEATH Month Day Year <u>10 4 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/1908</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Protect Laxle</u>		11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>	
13. FATHER'S NAME <u>Samuel Waters</u>				14. MOTHER'S MAIDEN NAME <u>Mary Younder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>215-03-6021</u>		17. INFORMANT <u>Mrs. M. Waters</u> Address <u>Poplar Ridge Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Squamous Carcinoma right lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with generalized metastases</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12 July</u> , 19 <u>56</u> , to <u>1 October</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1 October</u> , 19 <u>56</u> , and that death occurred at <u>10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Arthur L. Swirinski</u> M.D.				PHYSICIAN'S NAME (Type) <u>15 East Biddle Street</u> <u>Baltimore 2, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-8-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem Pic</u>		22d. LOCATION (City, town, or county) (State) <u>Ritchie Hgh - Glen Burne Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kennedy Inc</u> Address <u>Hollis + Gilmore St</u>				24a. REC'D BY REGISTRAR DATE <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Adell</u>	

CERTIFICATE OF DEATH

PLACE OF DEATH HOME		MOTHER MARY J. [illegible]	
DATE OF DEATH OCT 8 1955		PLACE OF BIRTH [illegible]	
SEX FEMALE		RACE WHITE	
AGE 43		OCCUPATION [illegible]	
CAUSE OF DEATH [illegible]		MANNER OF DEATH [illegible]	
SIGNATURE OF DECEASED [illegible]		SIGNATURE OF WITNESS [illegible]	
SIGNATURE OF PHYSICIAN [illegible]		SIGNATURE OF CORONER [illegible]	
SIGNATURE OF REGISTRAR [illegible]		SIGNATURE OF CLERK [illegible]	

BUREAU V. 3

OCT 8 1955

RECEIVED

9969

## CERTIFICATE OF DEATH

09954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A.A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Charles</i> First <i>Williams</i> Middle <i>Williams</i> Last		4. DATE OF DEATH <i>Oct 25 1956</i> Month <i>Oct</i> Day <i>25</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 25 1898</i> 9. AGE (In years last birthday) <i>58</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>New Orleans Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Cornelia Johnson</i> Address <i>Baltimore Heights</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Concussion of Stomach</i> <i>151K</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-25-56</i> , 19 <i>56</i> , to <i>Oct 2</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>9-20-56</i> , 19 <i>56</i> , and that death occurred at <i>9</i> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A.T. Allen</i>		DATE SIGNED <i>Oct 2 1956</i>	
PHYSICIAN'S NAME (Type) <i>A.T. ALLEN</i>		ADDRESS (Street, city or town, state) <i>62 CATHEDRAL ST</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Oct. 7/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>1st. Bapt. Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Heights Ind.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Annul A. Johnson</i> ADDRESS <i>Amesbury</i>		24a. REC'D BY REGISTRAR <i>DATE 8 1956</i>	
24b. REGISTRAR'S SIGNATURE <i>Wm. J. Tamm</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in block, it should be filed with the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and fill in the space provided for the burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 FilmG205 10-18-56 et

9931

## CERTIFICATE OF DEATH

09955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 South St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Wilson</u> Last <u>Wilson</u>				4. DATE OF DEATH Month <u>10</u> Day <u>6</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>3</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>A.A. Co. - Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Wilson</u>				14. MOTHER'S MAIDEN NAME <u>Louise Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-30-6711</u>		17. INFORMANT <u>Bella Wilkins - Balto. Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-9-56</u> , 19 <u>56</u> , to <u>10-6-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-4-56</u> , 19 <u>56</u> , and that death occurred at <u>1:30</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>C. L. Cochran St</u>			
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>				DATE SIGNED <u>10-6-56</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF <u>10-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Arnold, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>151055</u>		24b. REGISTRAR'S SIGNATURE <u>Wm J. Hunch</u>	

[illegible]

1957

Male Cat

2000

unstable (unstable)

550-30-012

Conrad Blake  
Marshall

1024th St.

4/12/20x

2-14-1883

D. 2. 15. 24. 2. 2. 2.

James Brown

Chloroform - 1000

**BUREAU V. S.**

OCT 15 1956

RECEIVED

Gravelly, red.

Received of Mr. J. C. Calverley  
the sum of £100-00-00

1

## INSTRUCTIONS

**1. ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**2. FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9970 Items 5,6,7 FilmG205 10-15-56 et

## CERTIFICATE OF DEATH

09956

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GLENBURNIE</u>		LENGTH OF STAY (in this place) <u>4 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>GLENBURNIE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>530 MONROE CIRCLE</u>				STREET ADDRESS (If rural give location) <u>530 MONROE CIRCLE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Anna Marie Zelinski</u>				<b>4. DATE OF DEATH</b> (Month) <u>10</u> (Day) <u>4</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>7-2-1896</u>	<b>9. AGE last birthday</b> <u>60</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____		<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>SOMERSET PA.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>YES</u>
<b>13. FATHER'S NAME</b> <u>?</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Edward J. Zelinski</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>4201 Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Artery Disease</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized Arteriosclerosis</u>						<u>10 yrs</u>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Obesity</u>						<u>10 yrs</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 6, 1955</u> , to <u>Oct 4, 1956</u> , that I last saw the deceased alive on <u>Oct 3, 1956</u> , and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>J.W. Prichard</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Green Borne, Md</u>		<b>DATE SIGNED</b> <u>10/4/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>10-8-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>MT. CARMEL</u>		<b>LOCATION</b> (City, town, or county) (State) <u>MT. CARMEL PA</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>L.J. Dealba</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Raymond C. Link</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>Oct 5 1956</u>							

# CERTIFICATE OF DEATH

Reg. No. 155

1. USUAL RESIDENCE OF DECEASED

MARYLAND

2. PLACE OF DEATH

CITY

3. HAND OF DECEASED

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INSTRUCTIONS

BUREAU V. S.

OCT 8 1956

RECEIVED